Name: _____ Single___ Divorced___
Last Middle First Married___ Widow___

Age: _____ Date of Birth: _____ Birth Place _____

Education _____ Years High School _____ Years College____ Years Post Graduate_____

Social Security # _____ Medicare # _____

Occupation _____

Reason for today's visit (please list all symptoms)

1 _____
2 _____
3 _____
4 _____
5 _____

OB/GYN HISTORY

MENSTRUAL PERIODS:

The first day of your recent period _____
The age your periods started _____
The age your period stopped _____
Are your periods regular?___Yes___No___N/A
The usual number of days your period lasts_____ days
The flow of your period___Light___Medium___Heavy
Do you have cramping or pain with your periods?___Yes___No
Do you have bleeding between periods?___Yes___No
Do you have bleeding with intercourse?___Yes___No
Do you have a vaginal discharge today?___Yes___No
Do you have urinary incontinence?___Yes___No
Are you currently sexually active?___Yes___No

What prescription medicines do you take regularly?

_____
_____
_____
_____
_____
_____
_____

If you are sexually active and can become pregnant, what do you or your partner use for birth control? _____
The month and year of your most recent Pap Smear _____
Have you ever had an abnormal Pap Smear in the past?
___Yes___No If yes, how long ago? _____
The year of your most recent mammogram _____

PREGNANCIES:

How many times were you pregnant? _____
How many live births have you had? _____
How many still births have you had? _____
How many miscarriages have you had? _____
How many abortions have you had?
How many tubal/ectopic pregnancies have you had? _____
How many cesarean sections have you had? _____

ALLERGIES: are you allergic to:

Latex _____ Aspirin _____
Novacaine _____ Codeine _____
Penicillin _____ Peanuts _____
Sulfa _____

	AGE	If Living Please List ALL Medical Conditions And Illnesses	Age at Death	If deceased Cause of Death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Have any relatives ever had Breast Cancer? _____

PERSONAL MEDICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY:

	AGE
high blood pressure	
heart disease	
heart attack	
stroke	
phlebitis	
emphysema	
asthma	
bronchitis	
pneumonia	
tuberculosis	
ulcer	
colitis	
gall bladder disease	
hepatitis	
mononucleosis	
thyroid problems	
diabetes	
urinary infection	
kidney stones	
epilepsy	
nervous or mental disorders	
arthritis	
gonorrhea	
syphillis	
herpes	
chlamydia	
veneral warts	
P.I.D.	
mumps	
chicken pox	
German measles	
rheumatic fever	
cancer (type)	
blood clots	
blood transfusions	

other _____

_____

_____

_____

SURGICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY:

	AGE
tonsillectomy	
hernia operation	
hemorrhoid operation	
thyroid operation	
gall bladder operation	
varicose vein operation	
D & C	
laparoscopy	
tubal ligation	
removal of tube or ovary	
hysterectomy	
breast biopsy	
colposcopy	
cone biopsy/LEEP	
lumpectomy	
mastectomy	

other: _____

_____

_____

Do you drink alcoholic beverages?___Yes___No
_____numbers of drinks per week

Do you have any sexual concerns you would like to discuss?_____

_____

_____

Do you currently smoke? ___Yes___No
_____packs per day currently,_____numbers of years.

If not smoking now, have you ever smoked?
___Yes___No

How long has it been since you last smoked?

_____

Name of Primary Care Physician: _____

Pharmacy Number: _____